Commonwealth of Massachusetts
Group Insurance Commission

Return completed form to the GIC Coordinator at your City/Town Benefits Office. Do not return to the GIC

Initial Municipal Insurance Enrollment Form – Medicare Retirees/Survivors

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #	Check one: ☐ Retiree ☐ Survivor — For Agency Use Only
___ ___		/ /	666/	Date of retirement ____/____/____
Name - Last		First	MI	

Address	City	State	Zip Code

Name of Municipality	Retirees: Do you receive a monthly retirement pension from this municipality? ☐ Yes ☐ No	Home Phone	Work Phone
		( )	( )

02 ☐ **HEALTH COVERAGE** — **Effective Date: / 01 /**

New Enrollment ☐ | Decline Coverage ☐ | Cancel Coverage ☐

☐ **Health** (Select one of the health plans below and individual or family coverage) **Insured's Medicare claim #** _____

Health Plan – Medicare Retirees / Survivors

☐ **Fallon Senior Plan (HMO)**

If enrolling in this Medicare plan, the GIC will notify the plan to forward their Medicare application to you to complete and return.

☐ **Harvard Pilgrim Medicare Enhance (Indemnity)**

☐ **Health New England MedPlus (HMO)**

☐ **Tufts Medicare Complement (HMO)**

☐ **Tufts Medicare Preferred (HMO)**

☐ **UniCare State Indemnity Plan / Medicare Extension (OME) (Indemnity)**
CIC: ☐ Yes ☐ No

Coverage
☐ **Individual**
☐ **Family**

SPOUSE/DEPENDENT INFORMATION – Only complete if covering spouse.

List below all family members, including your spouse or former spouse (if eligible), who will be covered under your health plan. Attach a separate sheet if additional space is required. Please provide all Social Security Numbers (required under Federal Law Section 111) and exact dates of birth for each dependent. To add a dependent age 19 to 26, you must also complete and return to the GIC a Dependent Age 19 to 26 Enrollment Form. **Important:** The Group Insurance Commission requires you to provide a copy of a marriage certificate, legal separation agreement, divorce decree, birth certificate, certificate of appointment as legal guardian, etc., for each person you list as a dependent.

Last Name	First	Middle	Relationship	Date of Birth	Sex	Social Security Number (required)

Reason for addition or deletion: _____ Effective date: _____

SPOUSE INFORMATION – Only complete if covering a spouse

Is your spouse employed? ☐ Yes ☐ No Name of employer _____ Address of employer _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No Name of insurance company _____

Policy/Certificate Number _____ Address of insurance company _____

Are you and/or your children covered under your spouse's group health insurance plan? You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim number _____

FORMER SPOUSE – Only complete if covering a former spouse

Name _____ Social Security Number _____ Date of Birth _____ Date of Divorce _____
Last First Middle

Address _____
Street City State Zip Code

Is your former spouse remarried? ☐ Yes ☐ No If yes, date of remarriage _____ Are you remarried? ☐ Yes ☐ No If yes, date of remarriage _____

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

SIGNATURE REQUIRED

Deduction Authorization: I authorize my employer, or direct my pension authority , to deduct from my payroll or pension check the amount required for the coverage I have selected.
Health Insurance: I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan.
Medicare Part B: I understand that if I cancel Medicare Part B coverage, I will no longer be eligible for GIC Coverage.
Survivors: If I am a surviving spouse of a GIC insured, I certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage.
Retirees must collect a pension from a public sector retirement system to be eligible for GIC coverage.

x _____ x _____
Signature of Applicant Date Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision